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	15G652	A. BUILDING 00 B. WING	01/14/2013

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DEVELOPMENTAL SERVICES INC	901 JOSEPH ST GREENSBURG, IN 47240

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W0000	This visit was for the fundamental recertification and state licensure survey. Survey dates: January 8, 9, 10, 11 and 14, 2013 Facility Number: 001190 Provider Number: 15G652 AIM Number: 100233930 Surveyor: Steven Schwing, Medical Surveyor III These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review was completed on 1/18/13 by Tim Shebel, Medical Surveyor III.	W0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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W0126	483.420(a)(4) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must allow individual clients to manage their financial affairs and teach them to do so to the extent of their capabilities. Based on observation and interview for 2 of 3 non-sampled clients (#1 and #2), the facility failed to ensure the clients' received training using real money. Findings include: An observation was conducted at the group home on 1/9/13 from 4:11 PM to 5:42 PM. At 4:37 PM, staff #1 provided training to client #2 regarding money. Client #2 was asked to identify paper money amounts as well as coins. Staff #1 used plastic coins and fake paper money. At 4:42 PM, staff #1 provided training to client #1 regarding money. Client #1 was asked to identify different plastic coins. An interview with staff #3 was conducted on 1/9/13 at 4:51 PM. Staff #3 indicated the clients used plastic paper and coins for their training. An interview was conducted with the Qualified Mental Retardation Professional (QMRP) on 1/10/13 at 12:00 PM. The QMRP indicated the clients should be using real money for the	W0126	W126 QIDP will retrain staff on appropriate teaching techniques and the importance of using real money when working with clients on money goals. QIDP or designee will observe at least weekly for one month and at least monthly thereafter to ensure compliance in this area. Responsible for QA: QIDP	02/13/2013

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	training. An interview was conducted with Administrative Staff (AS) #1 on 1/14/13 at 1:36 PM. AS #1 indicated the clients should be using real money for their training. 9-3-2(a)			

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W0149	483.420(d)(1) STAFF TREATMENT OF CLIENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. Based on record review and interview for 1 of 6 incident/investigative reports reviewed affecting client #2, the facility failed to implement its policies and procedures for conducting an investigation of an injury of unknown origin. Findings include: A review of the facility's incident/investigative reports was conducted on 1/8/13 at 1:33 PM. A Medical Incident Report, dated, 10/29/12 at 3:40 AM, indicated, "There was a loud boom that came from the bathroom. When I went to check [client #2] was on her way up to the front. She didn't have her slippers on so I went to get them. There was blood on bedroom floor. Her blankets were also on floor suggesting she might have fell (sic) out of bed. I put dressing and pressure on her ear to stop the bleeding. I called the emergency pager, [name of Qualified Mental Retardation Professional Assistant], and 911." The report indicated client #2 had a cut, front and back, to her right ear and a bump on her right forehead. The report indicated the bump was 2 inches around.	W0149	W149 Agency policy and procedures on prohibiting mistreatment, neglect, or abuse of clients, reporting of incidents to the state, and investigations were reviewed and determined appropriate. SGL manager will retrain QIDP's on conducting thorough and timely investigations per agency policy. SGL manager will review investigations to ensure compliance in this area. Responsible for QA: SGL Manager, QIDP	02/13/2013

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	The Bureau of Developmental Disabilities Services report, dated 10/29/12, indicated the incident occurred at "approximately 3:00 AM." The report indicated, "[Staff #6] reported that [client #2] had fallen and struck her right side of her head and ear on the bedside table... [Client #2] had gotten tangled in the bedcovers and tried to get out of bed when she fell. Injury was a large knot on the front right forehead and a cut behind the right ear." The facility did not provide documentation of an investigation into the incident. There was no documentation client #2 was interviewed. A review of the facility's policy on conducting investigations was conducted on 1/8/13 at 1:04 PM. The facility's Protocol for Completing Investigations, dated 1/3/06, indicated, "Any event involving the potential or actual risk of harm to a client served, will be documented, reported, investigated and corrective action taken to alleviate the potential for future risk." The investigation must be initiated within 24 hours and completed within 5 working days." The policy indicated, in part, "...will be investigated immediately and thoroughly." The policy indicated, "1. Instances of suspected violations of rights, abuse or neglect, or inadequate protection of the health and safety of			

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	individuals served will be investigated immediately and thoroughly. Examples of inadequate protection of health and safety include but are not limited to: injuries of unknown origin, behavior incidents resulting in client/staff injuries, accidents resulting in the need of medical treatment, incidents caused by possible staff neglect and suspected criminal activity by staff or clients. The investigation must be thorough and shall include the following: a. Review of the incident reports, b. Interview with the client and or guardian and/or advocate, c. Interview of all staff involved including whenever possible. The policy indicated, "The investigative report should include the following information as applicable: a. Description of the concern, b. Review and summary of any documentation, c. Listing and summary of personal interviews, d. Review of agency policies, e. A summary of findings/conclusions investigation has discovered, f. Resolution/outcome, and g. Suggestive Corrective Action to prevent further issues from reoccurring." An interview was conducted with the Qualified Mental Retardation Professional (QMRP) on 1/10/13 at 12:00 PM. The QMRP indicated an investigation should have been conducted.			

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	An interview was conducted with Administrative Staff (AS) #1 on 1/14/13 at 1:36 PM. AS #1 indicated the incident should have been investigated as an injury of unknown origin since it was not observed. 9-3-2(a)			

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W0154	483.420(d)(3) STAFF TREATMENT OF CLIENTS The facility must have evidence that all alleged violations are thoroughly investigated. Based on record review and interview for 1 of 6 incident/investigative reports reviewed affecting client #2, the facility failed to conduct an investigation of an injury of unknown origin. Findings include: A review of the facility's incident/investigative reports was conducted on 1/8/13 at 1:33 PM. A Medical Incident Report, dated 10/29/12 at 3:40 AM, indicated, "There was a loud boom that came from the bathroom. When I went to check [client #2] was on her way up to the front. She didn't have her slippers on so I went to get them. There was blood on bedroom floor. Her blankets were also on floor suggesting she might have fell (sic) out of bed. I put dressing and pressure on her ear to stop the bleeding. I called the emergency pager, [name of Qualified Mental Retardation Professional Assistant], and 911." The report indicated client #2 had a cut, front and back, to her right ear and a bump on her right forehead. The report indicated the bump was 2 inches around. The Bureau of Developmental Disabilities Services report, dated 10/29/12, indicated	W0154	W154 Agency policy and procedures on prohibiting mistreatment, neglect, or abuse of clients, reporting of incidents to the state, and investigations were reviewed and determined appropriate. SGL manager will retrain QIDP's on conducting thorough and timely investigations per agency policy. SGL manager will review investigations to ensure compliance in this area. Responsible for QA: SGL Manager, QIDP	02/13/2013

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	the incident occurred at "approximately 3:00 AM." The report indicated, "[Staff #6] reported that [client #2] had fallen and struck her right side of her head and ear on the bedside table... [Client #2] had gotten tangled in the bedcovers and tried to get out of bed when she fell. Injury was a large knot on the front right forehead and a cut behind the right ear." The facility did not provide documentation of an investigation into the incident. There was no documentation client #2 was interviewed. An interview was conducted with the Qualified Mental Retardation Professional (QMRP) on 1/10/13 at 12:00 PM. The QMRP indicated an investigation should have been conducted. An interview was conducted with Administrative Staff (AS) #1 on 1/14/13 at 1:36 PM. AS #1 indicated the incident should have been investigated as an injury of unknown origin since it was not observed. 9-3-2(a)			

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W0210	483.440(c)(3) INDIVIDUAL PROGRAM PLAN Within 30 days after admission, the interdisciplinary team must perform accurate assessments or reassessments as needed to supplement the preliminary evaluation conducted prior to admission. Based on record review and interview for 1 of 3 clients in the sample (#6), the facility failed to ensure her Comprehensive Functional Assessment (CFA) was updated or revised annually. Findings include: A review of client #6's record was conducted on 1/10/13 at 10:17 AM. Client #6's current CFA was dated 2011. There was no documentation in her record indicating the CFA was updated prior to the Individual Program Plan (IPP), dated 10/17/12 to 10/17/13 being revised. An interview was conducted with the Qualified Mental Retardation Professional (QMRP) on 1/10/13 at 12:00 PM. The QMRP indicated the CFA should be updated annually. An interview was conducted with Administrative Staff (AS) #1 on 1/14/13 at 1:36 PM. AS #1 indicated the client's CFA should be updated annually. 9-3-4(a)	W0210	W210 QIDP has updated Client #6 comprehensive functional assessment and included this with her current program plan. QIDP's have been retrained on ensuring that all components of the client's program plan are updated at least annually. QIDP's will submit a checklist to the SGL Manager after the completion of the annual program plan indicating all components are complete. Responsible for QA: QIDP, SGL Manager	02/13/2013

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W0249	483.440(d)(1) PROGRAM IMPLEMENTATION As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan. Based on observation, record review and interview for 5 of 6 clients (#1, #2, #4, #5 and #6) living in the group home, the facility failed to ensure staff implemented the clients' program plans as written. Findings include: Observations were conducted at the group home on 1/9/13 from 4:11 PM to 5:42 PM and 1/10/13 from 5:54 AM to 7:31 AM. 1) On 1/9/13 at 4:22 PM, client #6 received her medications (Propranolol for tremors and Artificial Tears for dry eyes) from staff #3. Client #6 was not prompted to identify more than one medication including her PRN (as needed) medications, prepare for a medication pass, identify the side effects of her medications. On 1/9/13 at 4:28 PM, client #2 received her medication (Genteal for ocular irritation) from staff #3. Client #2 was	W0249	W249 Staff will be retrained on implementation of each client's individual program plans. Specific training will include but not be limited to the implementation of medication training objectives during each med pass for each client and following the dining plan for client #6. QIDP or designee will observe at least weekly for one month then monthly thereafter to ensure compliance in these areas. Responsible for QA: QIDP	02/13/2013

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	not prompted to identify the illness PRN medications were used for and identify her medication. On 1/9/13 at 4:48 PM, client #4 received her medication (Ibuprofen for a headache) from staff #3. Client #4 was not asked to to prepare and then take her medication and identify her medication. On 1/9/13 at 5:06 PM, client #5 received her medications (Meclizine for dizziness and balance and Meloxicam for arthritis) from staff #3. Client #5 was not prompted to record her medication administration daily, self-medicate with verbal prompts, and learn the names of her medications On 1/9/13 at 5:09 PM, client #1 received her medication (Calgest antacid for osteoporosis and Vitamin D-3 as a supplement) from staff #3. Client #1 was not prompted to continue reviewing her medications and learn the purpose of each house PRN medication. On 1/9/13 at 5:11 PM, client #2 received her medication (Calcium with Vitamin D for osteoporosis) from staff #3. Client #2 was not prompted to identify the illness PRN medications were used for and identify her medication.			

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	On 1/10/13 at 5:58 AM, client #2 received her medications (Genteal for ocular irritation, Calcium with vitamin D as a supplement, Glipizide for hypoglycemia, Lisinopril for hypoglycemia, Namenda for dementia, Ketotifen eye drops for ocular irritation) from staff #1. Client #2 was not prompted to identify the illness PRN medications were used for and identify her medication. On 1/10/13 at 6:40 AM, client #6 received her medications (Calcium with vitamin D as a supplement, Escitalopram for anxiety, Oxybutynin for incontinence, Propranolol for tremors, Artificial Tears for dry eyes, and Patanol for allergic conjunctivitis) from staff #1. Client #6 was not prompted to identify more than one medication including her PRN medications, prepare for a medication pass, identify the side effects of her medications. A review of client #1's record was conducted on 1/10/13 at 11:52 AM. Client #1's Individual Program Plan (IPP), dated 1/10/12 - 1/10/13, indicated she had medication training objectives to continue reviewing her medications and learn the purpose of each house PRN medication. A review of client #2's record was			

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	conducted on 1/10/13 at 11:48 AM. Client #2's IPP, dated 3/12 - 3/13, indicated she had medication administration training objectives to prepare for her medication pass, identify the illness PRNs were used for, and identify all her administered medications. A review of client #4's record was conducted on 1/10/13 at 10:53 AM. Client #4's IPP, dated 8/3/12 - 8/3/13, indicated she had a medication training objective to prepare and then take her medications and identify her medications. A review of client #5's record was conducted on 1/10/13 at 11:56 AM. Client #5's IPP, dated 5/2/12 - 5/2/13, indicated she had a medication training objective to record her medication administration daily, self-medicate with verbal prompts, and learn the names of her medications. A review of client #6's record was conducted on 1/10/13 at 10:17 AM. Client #6's IPP, dated 10/17/12 - 10/17/13, indicated she had a medication training objective to identify more than one medication including her PRN medications, prepare for a medication pass, identify the side effects of her medications.			

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	An interview was conducted with the Qualified Mental Retardation Professional (QMRP) on 1/10/13 at 12:00 PM. The QMRP indicated the clients' medication training objectives should be implemented at each medication pass. An interview was conducted with Administrative Staff (AS) #1 on 1/14/13 at 1:36 PM. AS #1 indicated the medication training objectives should be implemented at each medication pass. 2) On 1/9/13 from 5:12 PM to the end of dinner at 5:39 PM, client #6 was not observed to hold a prop in her right hand to prevent her from stuffing her mouth. On 1/10/13 from 6:15 AM to 6:39 AM, client #6 was not observed to hold a prop in her right hand to prevent her from stuffing her mouth. At 6:33 AM, client #6 ate her toast with no prompts to slow down. Client #6 took bite after bite with no prompts from staff. A review of client #6's record was conducted on 1/10/13 at 10:17 AM. Client #6's Dining Plan, dated 3/1/12, indicated she needed verbal and physical prompts to slow down while eating and to take smaller bites. The plan indicated she needed adaptations to prevent choking such as a prop in her right hand. The plan indicated, "Verbal and physical prompts			

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	should be offered during the meal to remind [client #6] to slow down while eating. [Client #6] should use prop in right hand to prevent stuffing mouth." An interview was conducted with the Qualified Mental Retardation Professional (QMRP) on 1/10/13 at 12:19 PM. The QMRP indicated client #6's dining plan should be implemented at every meal. An interview was conducted with Administrative Staff (AS) #1 on 1/14/13 at 1:36 PM. AS #1 indicated client #6's dining plan should be implemented at every meal, as written. 9-3-4(a)			

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	15G652	A. BUILDING 00 B. WING	01/14/2013

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W0262	483.440(f)(3)(i) PROGRAM MONITORING & CHANGE The committee should review, approve, and monitor individual programs designed to manage inappropriate behavior and other programs that, in the opinion of the committee, involve risks to client protection and rights. Based on record review and interview for 1 of 3 clients in the sample (#6), the specially constituted committee (HRC) failed to review, approve and monitor client #6's Behavior Support Plan (BSP) with restrictions. Findings include: A review of client #6's record was conducted on 1/10/13 at 10:17 AM. Client #6's BSP, dated 10/17/12, included the use of two psychotropic medications (Lexapro and Propranolol). There was no documentation in client #6's record the HRC reviewed, approved and monitored her restrictive BSP. An interview was conducted with the Qualified Mental Retardation Professional (QMRP) on 1/10/13 at 12:00 PM. The QMRP indicated prior to implementing the BSP, the HRC should review and approve the plan. An interview was conducted with Administrative Staff (AS) #1 on 1/14/13	W0262	W262 HRC review and consent for client #6's BSP will be obtained. QIDP's will be retrained on agency policy and state requirements for HRC approval for any restrictive behavior plan. QIDP will obtain at least annually and as needed HRC approval on every BSP involving restrictions. QIDP will review each BSP at least annually and as needed to ensure HRC approval is obtained as needed. Responsible for QA: QIDP	02/13/2013

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	at 1:36 PM. AS #1 indicated the HRC should review and approve the plan prior to implementation. 9-3-4(a)			

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W0317	483.450(e)(4)(ii) DRUG USAGE Drugs used for control of inappropriate behavior must be gradually withdrawn at least annually in a carefully monitored program conducted in conjunction with the interdisciplinary team, unless clinical evidence justifies that this is contraindicated. Based on record review and interview for 1 of 3 clients in the sample (#3), the facility failed to ensure client #3's plan of reduction for her psychotropic medication was attainable. Findings include: A review of client #3's record was conducted on 1/10/13 at 11:14 AM. Client #3's Behavior Support Plan, dated 3/12/12, indicated she had a psychotropic medication (Celexa). The plan for reducing Celexa indicated, "Medication reduction will be sought in conjunction with psychiatric, guardian review and consultation per below criteria: 0 instances each month of signs/symptoms of depression for six months." An interview was conducted with the Qualified Mental Retardation Professional (QMRP) on 1/10/13 at 12:00 PM. The QMRP indicated the current plan of reduction was not likely to be achieved. The QMRP indicated the plan for reducing client #3's psychotropic	W0317	W317 QIDP will review client #3's BSP and revise the criteria for medication reduction to ensure it is attainable. The revised plan will be submitted for approval by the guardian and the HRC. QIDP will review each BSP at least annually and as needed to ensure compliance in this area. Responsibility for QA: QIDP	02/13/2013

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	medication needed to be revised in order to make the reduction more attainable. An interview was conducted with Administrative Staff (AS) #1 on 1/14/13 at 1:36 PM. AS #1 indicated zero instances each month for six consecutive months was not attainable. AS #1 indicated the plan needed to be revised to make the reduction more attainable. 9-3-5(a)			

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W0323	483.460(a)(3)(i) PHYSICIAN SERVICES The facility must provide or obtain annual physical examinations of each client that at a minimum includes an evaluation of vision and hearing. Based on record review and interview for 1 of 3 clients in the sample (#6), the facility failed to ensure client #6's hearing was evaluated. Findings include: A review of client #6's record was conducted on 1/10/13 at 11:14 AM. Client #6's record did not contain documentation indicating her hearing had been evaluated. Her 5/24/12 annual physical did not include an assessment of her hearing. An interview was conducted with the Qualified Mental Retardation Professional (QMRP) on 1/10/13 at 12:00 PM. The QMRP indicated client #6's hearing should have been evaluated within the past year. An interview was conducted with Administrative Staff (AS) #1 on 1/14/13 at 1:36 PM. AS #1 indicated client #6's hearing should be evaluated annually. 9-3-6(a)	W0323	W323 QIDP's have been retrained on requirements for timely annual medical exams to include hearing and vision for each client. Client #6 will be scheduled for hearing eval. QIDP and agency nurse will review each client's chart at least monthly to ensure all medical exams are obtained timely. Responsible for QA: QIDP	02/13/2013

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W0356	483.460(g)(2) COMPREHENSIVE DENTAL TREATMENT The facility must ensure comprehensive dental treatment services that include dental care needed for relief of pain and infections, restoration of teeth, and maintenance of dental health. Based on record review and interview for 1 of 3 clients in the sample (#6), the facility failed to ensure a follow-up dental appointment was held as scheduled and recommended. Findings include: A review of client #6's record was conducted on 1/10/13 at 10:17 AM. Client #6's most recent dental appointment, dated 4/25/12, indicated a follow-up appointment was scheduled for 10/31/12. The appointment form indicated, "Attempting to hold onto teeth as long as possible but will eventually need to consider exts (extractions)." There was no documentation a follow-up was held. An interview was conducted with the Qualified Mental Retardation Professional (QMRP) on 1/10/13 at 12:06 PM. The QMRP indicated client #6's guardian took the responsibility of taking client #6 to her appointments. The QMRP indicated the next dental appointment was scheduled for April	W0356	W356 QIDP's will be retrained on requirements for timely medical and dental care for each client. Client #6 will receive routine dental treatment as recommended by her dentist. This documentation will be obtained and filed appropriately. QIDP and her assistant will review each client's record to ensure all medical/dental evals are timely. Responsible for QA: QIDP	02/13/2013

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	2013. An interview was conducted with Administrative Staff (AS) #1 on 1/14/13 at 1:36 PM. AS #1 indicated client #6 should have a follow-up as scheduled and recommended by the dentist. 9-3-6(a)			

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W0362	483.460(j)(1) DRUG REGIMEN REVIEW A pharmacist with input from the interdisciplinary team must review the drug regimen of each client at least quarterly. Based on record review and interview for 1 of 3 clients in the sample (#6), the facility failed to ensure client #6's drug regimen was reviewed quarterly by the pharmacist. Findings include: A review of client #6's record was conducted on 1/10/13 at 10:17 AM. The pharmacist reviewed client #6's drug regimen on 7/5/12, 10/1/12 and 1/2/13. There was no documentation in client #6's record indicating the pharmacist reviewed her drug regimen prior to 7/5/12. An interview was conducted with the Qualified Mental Retardation Professional (QMRP) on 1/10/13 at 12:00 PM. The QMRP indicated the pharmacy review should be conducted quarterly. An interview was conducted with Administrative Staff (AS) #1 on 1/14/13 at 1:36 PM. AS #1 indicated pharmacy reviews should be conducted quarterly and be in the record for review. 9-3-6(a)	W0362	W362 Pharmacy audits were performed on 1/25/2012 and 4/26/2012. This documentation had been inadvertently purged from the house book. Staff will be retrained regarding appropriate timeframes for purging. QIDP's are given a copy of the pharmacy audits and will conduct random audits of client records quarterly to ensure documentation is in place. Responsible for QA: QIDP	02/13/2013

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W0448	483.470(i)(2)(iv) EVACUATION DRILLS The facility must investigate all problems with evacuation drills, including accidents. Based on record review and interview for 6 of 6 clients living in the group home (#1, #2, #3, #4, #5 and #6), the facility failed to ensure issues noted during evacuation drills were investigated. Findings include: A review of the facility's evacuation drills was conducted on 1/10/13 at 9:45 AM. There was no documentation an investigation was conducted for the following drills. This affected clients #1, #2, #3, #4, #5 and #6. 1. On 3/24/12 at 11:00 PM, a fire drill took 5 minutes to complete. 2. On 4/14/12 (no time documented), the fire drill took 5 minutes to complete. 3. On 5/9/12 (no time documented), the fire drill took 5 minutes to complete. 4. On 6/3/12 (no time documented), the fire drill took 5 minutes to complete. 5. On 10/6/12 at 6:00 PM, the fire drill took 5 minutes to complete. 6. On 10/10/12 at 12:30 AM, the fire drill took 5 minutes to complete. 7. On 11/25/12 at 9:00 AM, the fire drill took 4 minutes to complete. 8. On 12/20/12 at 5:00 PM, the fire drill took 5 minutes to complete.	W0448	W448 Evacuation procedures and documentation forms were reviewed. Forms have been revised to include direction to staff to report to QIDP anytime a client evacuation takes longer than 2 minutes. QIDP will retrain staff on procedures for conducting evacuation drills and proper documentation of each drill to include notification to QIDP of problems occurring with any client during the drill. QIDP's will be retrained on investigating any problems noted during evacuation drills. QIDP reviews evacuation drills monthly and forwards copies of these to SGL Manager for review to ensure compliance in this area. Responsible for QA: QIDP, SGL Manager	02/13/2013

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	An interview was conducted with the Qualified Mental Retardation Professional (QMRP) on 1/10/13 at 12:00 PM. The QMRP indicated the targeted time for completing fire drills was under 2 minutes. The QMRP indicated the drills taking longer than 2 minutes should have been investigated. An interview was conducted with Administrative Staff (AS) #1 on 1/14/13 at 1:36 PM. AS #1 indicated issues noted during evacuation drills should be investigated. AS #1 indicated the targeted time for completing drills was 1-2 minutes. 9-3-7(a)			

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W0463	483.480(a)(4) FOOD AND NUTRITION SERVICES The client's interdisciplinary team, including a qualified dietitian and physician must prescribe all modified and special diets. Based on observation, record review and interview for 1 of 3 clients in the sample (#6), the facility failed to ensure client #6's diet was reviewed periodically. Findings include: On 1/9/13 from 5:12 PM to the end of dinner at 5:39 PM, client #6 was not observed to hold a prop in her right hand to prevent her from stuffing her mouth. On 1/10/13 from 6:15 AM to 6:39 AM, client #6 was not observed to hold a prop in her right hand to prevent her from stuffing her mouth. At 6:33 AM, client #6 ate her toast with no prompts to slow down. Client #6 took bite after bite with no prompts from staff. A review of client #6's record was conducted on 1/10/13 at 10:17 AM. Client #6's Dining Plan, dated 3/1/12, indicated she needed verbal and physical prompts to slow down while eating and to take smaller bites. The plan indicated she needed adaptations to prevent choking such as a prop in her right hand. The plan indicated, "Verbal and physical prompts should be offered during the meal to remind [client #6] to slow down while	W0463	W463 Dietician was contacted and has conducted an assessment for each client in this home. QIDP has been retrained on requirement for periodic, at least annual, review by dietician. QIDP will audit client's file at time of annual to ensure dietician review is current and update dining plan as needed. Responsible for QA: QIDP	02/13/2013

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	eating. [Client #6] should use prop in right hand to prevent stuffing mouth." Client #6's most recent dietary review by the dietician was dated 4/11/11. An interview was conducted with the Qualified Mental Retardation Professional (QMRP) on 1/10/13 at 12:19 PM. The QMRP indicated she was unable to locate client #6's current dietary review. On 1/10/13 at 3:24 PM, the QMRP indicated the dietician had been to the home and conducted the dietary review. The QMRP indicated the dietician failed to conduct a review in 2012. An interview was conducted with Administrative Staff (AS) #1 on 1/14/13 at 1:36 PM. AS #1 indicated the dietician should conduct annual reviews. AS #1 indicated client #6 had mealtime issues noted in her Dining Plan. 9-3-8(a)			

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W0488	483.480(d)(4) DINING AREAS AND SERVICE The facility must assure that each client eats in a manner consistent with his or her developmental level. Based on observation and interview for 6 of 6 clients living in the group home (#1, #2, #3, #4, #5 and #6), the facility failed to ensure the clients served themselves, poured their own drinks and cleaned up after breakfast. Findings include: An observation was conducted at the group home on 1/10/13 from 5:54 AM to 7:31 AM. At 6:05 AM, staff #1 poured milk into 4 coffee cups sitting on the counter next to the coffee maker. At 6:10 AM, staff #1 stated to client #4, "I'm going to get your tea going." Client #4 was not prompted to assist with making her tea. At 6:13 AM, staff #1 poured coffee into client #1, #2 and #6's coffee cups. At 6:18 AM, staff #1 microwaved and took the oatmeal to the table for client #3. Staff #1 poured client #4's milk. Staff #1 poured client #3's milk into her oatmeal. At 6:23 AM, staff #1 poured clients #2, #3, #4 and #6's apple juice. Staff #1 put client #3's toast in the toaster. At 6:27 AM, staff #1 put client #5's coffee on the dining room table. Staff #5 took client #6's empty bowl to the sink. Staff #1 took client #6's plate and cups to	W0488	W488 QIDP will retrain staff in how to support each client in the meal preparation and clean up, and in dining that is consistent with their skill level and as identified in their IPP's especially at breakfast. The QIDP or designee will observe breakfast routine at least weekly for one month to ensure compliance in this area. Random observations will continue at least monthly. Responsible for QA: QIDP	02/13/2013

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	the sink. An interview was conducted with the Qualified Mental Retardation Professional (QMRP) on 1/10/13 at 12:00 PM. The QMRP indicated the clients should serve and clean up after themselves. An interview was conducted with Administrative Staff (AS) #1 on 1/14/13 at 1:36 PM. AS #1 indicated the clients should participate to their abilities. AS #1 indicated the clients at this group home were capable of serving themselves and doing the clean up. 9-3-8(a)			

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W9999	State Findings The following Community Residential Facilities for Persons with Developmental Disabilities Rule was not met: 1) 460 IAC 9-3-3 Facility Staffing (e) Prior to assuming residential job duties and annually thereafter, each residential staff person shall submit written evidence that a Mantoux (5TU, PPD) tuberculosis skin test or chest x-ray was completed. The result of the Mantoux shall be recorded in millimeter of induration with the date given, date read, and by whom administered. If the skin test result is significant (ten (10) millimeters or more), then a chest film shall be done with other physical and laboratory examinations as necessary to complete a diagnosis. Prophylactic treatment shall be provided as per diagnosis for the length of time prescribed by the physician. THIS STATE RULE WAS NOT MET AS EVIDENCED BY: Based on record review and interview for 1 of 3 employee files reviewed (Direct Care Staff #3), the facility failed to ensure	W9999	W9999 Staff files were audited and all Mantoux screenings are current at this time.	02/13/2013

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DEVELOPMENTAL SERVICES INC	901 JOSEPH ST GREENSBURG, IN 47240

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	an annual Mantoux (5TU, PPD) tuberculosis screening was conducted. Findings include: A review of the facility's employee files was conducted on 1/8/13 at 1:08 PM. Direct Care Staff #3 had a negative Mantoux on 8/22/11. There was no documentation Direct Care Staff #3 had a Mantoux conducted since 8/22/11. An interview was conducted with the Administrative Staff (AS) #1 on 1/8/13 at 1:44 PM. AS #1 indicated the staff should have an annual Mantoux. 9-3-3(e)			